		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026328

Facility Name: Oakview Heights Continuous Care & Rehabilitation Center

Address: 1320 West Ninth St. (Number) Mt. Carmel (City) 62863 (Zip Code)

County: Wabash

Telephone Number: (618) 263-4337 **Fax #** (618) 262-7080

IDPA ID Number: 371104153001

Date of Initial License for Current Owners: 06/01/81

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 09/01/01 to 08/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser, LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,400	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,380	4,303	1,653	10,336	8
9	SNF/PED					9
10	ICF	11,691	6,308		17,999	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,071	10,611	1,653	28,335	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.52%

D. How many bed-hold days during this year were paid by Public Aid?
N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01//81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,653

Medicare Intermediary AdminaStar Federal (Indianapolis)

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 08/31/02 Fiscal Year: 08/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabi # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	202,568	36,986	6,522	246,076		246,076	(6,792)	239,284			1
2	Food Purchase		175,385		175,385		175,385	(9,774)	165,611			2
3	Housekeeping	108,503	9,941		118,444		118,444		118,444			3
4	Laundry	18,298	4,262	63,017	85,577		85,577		85,577			4
5	Heat and Other Utilities			72,397	72,397		72,397		72,397			5
6	Maintenance	43,625	13,768	38,334	95,727		95,727		95,727			6
7	Other (specify):*											7
8	**TOTAL General Services**	372,994	240,342	180,270	793,606		793,606	(16,566)	777,040			8
	B. Health Care and Programs											
9	Medical Director			9,200	9,200		9,200		9,200			9
10	Nursing and Medical Records	935,397	104,143	18,079	1,057,619		1,057,619		1,057,619			10
10a	Therapy		3,187	134,211	137,398		137,398		137,398			10a
11	Activities	41,979	496		42,475		42,475		42,475			11
12	Social Services	20,959		3,939	24,898		24,898		24,898			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	998,335	107,826	165,429	1,271,590		1,271,590		1,271,590			16
	C. General Administration											
17	Administrative	102,062			102,062		102,062		102,062			17
18	Directors Fees											18
19	Professional Services			22,033	22,033		22,033		22,033			19
20	Dues, Fees, Subscriptions & Promotions			14,138	14,138		14,138	(3,710)	10,428			20
21	Clerical & General Office Expenses	43,321	9,305	34,417	87,043		87,043		87,043			21
22	Employee Benefits & Payroll Taxes			188,270	188,270		188,270		188,270			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,042	10,042		10,042	(1,438)	8,604			24
25	Other Admin. Staff Transportation			2,664	2,664		2,664		2,664			25
26	Insurance-Prop.Liab.Malpractice			56,659	56,659		56,659		56,659			26
27	Other (specify):*											27
28	**TOTAL General Administration**	145,383	9,305	328,223	482,911		482,911	(5,148)	477,763			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,516,712	357,473	673,922	2,548,107		2,548,107	(21,714)	2,526,393			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number: Oakview Heights Continuous Care & Rehabilitation Center #0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			124,194	124,194		124,194		124,194			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,596	22,596		22,596	(166)	22,430			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,085	12,085		12,085		12,085			35
36	Other (specify):*											36
37	**TOTAL Ownership**			158,875	158,875		158,875	(166)	158,709			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		27,086	263	27,349		27,349		27,349			39
40	Barber and Beauty Shops			8,078	8,078		8,078		8,078			40
41	Coffee and Gift Shops			87,600	87,600		87,600		87,600			41
42	Provider Participation Fee											42
43	Other (specify):* Nonallowable Costs			49,945	49,945		49,945	(49,945)				43
44	**TOTAL Special Cost Centers**		27,086	145,886	172,972		172,972	(49,945)	123,027			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,516,712	384,559	978,683	2,879,954		2,879,954	(71,825)	2,808,129			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Cente # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,774)	5		4
5	Telephone, TV & Radio in Resident Rooms	(1,506)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(166)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,250)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,000)	43		24
25	Fund Raising, Advertising and Promotional	(8,625)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,549)	43		28
29	Other-Attach Schedule (See attached)	(23,955)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (71,825)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (71,825)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Oakview Heights Continuous Care & Rehabilitation Center

ID# 0026328

Report Period Beginning: 09/01/01

Ending: 08/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center **#** 0026328 **Report Period Beginning:** 09/01/01 **Ending:** 08/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(9,774)	0	0	0	0	0	0	0	0	0	0	(9,774)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,774)	0	0	0	0	0	0	0	0	0	0	(9,774)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,250)	0	0	0	0	0	0	0	0	0	0	(3,250)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,250)	0	0	0	0	0	0	0	0	0	0	(3,250)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,024)	0	0	0	0	0	0	0	0	0	0	(13,024)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 **Report Period Beginning:** 09/01/01 **Ending:** 08/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(166)	0	0	0	0	0	0	0	0	0	0	(166)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(166)	0	0	0	0	0	0	0	0	0	0	(166)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(34,680)	0	0	0	0	0	0	0	0	0	0	(34,680)	43
44	**TOTAL Special Cost Centers**	(34,680)	0	0	0	0	0	0	0	0	0	0	(34,680)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(47,870)	0	0	0	0	0	0	0	0	0	0	(47,870)	45

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule of Board of Directors						
	None	N/A				
No directors provided direct services or had any interest in entities that had business transactions with the facility.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V				N/A				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehab # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4		N/A									4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Cente # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10				N/A						10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabil # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Fifth/Third Bank		X	Mortgage	$15,000.00	10/01/98	$ 1,500,000	$	10/30/01	0.0675	$ 15,024	1
2	United Leasing		X	Lease obligation-phone sys.	$475.00	08/24/98	28,496	5,699	8/24/03	0.0850	1,955	2
3	Galaxy Medical Products		X	Lease obl.-air mattress	$750.00	05/01/01	1,500		10/31/01			3
4	Gen'l Baptist-Campbell, MO	X		Mortgage	None	11/05/01	1,538,793	1,538,793	Demand			4
5												5
	Working Capital											
6	First Bank		X	Line of credit	Line of credit	11/05/01	200,000	176,660	11/05/02	0.0550	647	6
7	Fifth/Third Bank		X	Line of credit	Line of credit	9/18/98	100,000		11/05/01	0.0675	4,970	7
8												8
9	TOTAL Facility Related				$16,225.00		$ 3,368,789	$ 1,721,152			$ 22,596	9
	B. Non-Facility Related*											
10								Less: Interest income offset			(166)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (166)	14
15	TOTALS (line 9+line14)						$ 3,368,789	$ 1,721,152			$ 22,430	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

No real estate taxes paid. Not-for-profit entity.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakview Heights Continuous Care & Rehabilitation Cente COUNTY Wabash

FACILITY IDPH LICENSE NUMBER 0026328

CONTACT PERSON REGARDING THIS REPORT Scott Cole, Administrator

TELEPHONE (618) 263-4337 FAX #: (618) 262-7080

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	N/A - Not-for-profit entity		$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,602 B. General Construction Type: Exterior Concrete/Sandstone Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident use	352,863	1981	$ 119,216	1
2	Resident use	270,630	1994	60,000	2
3	TOTALS	623,493		$ 179,216	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	160		1981	1981	$ 1,310,463	$ 46,922	40	$ 46,922	$	$ 993,820	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1984	5,654		7			5,654	9
10	Building Improvements			1985	9,568		7			9,568	10
11	Building Improvements			1984	6,143		10			6,143	11
12	Building Improvements			1984	6,236		10			6,237	12
13	Building Improvements			1994	2,914	291	10	291		2,500	13
14	Land Improvements			1982	14,363		10			14,363	14
15	Roof			1996	68,042	2,268	30	2,268		13,797	15
16	Walk-in Freezer			1996	24,497	3,500	7	3,500		21,915	16
17											17
18	Awning			1997	8,300	533	15	533		2,705	18
19	Air Conditioner Units			1997	7,687	1,096	7	1,096		6,185	19
20	Roof (final)			1997	11,450	382	30	382		2,228	20
21	Door Knobs/Locks			1998	3,448	494	7	494		2,467	21
22	Electrical - new wiring			1998	23,632	945	25	945		4,568	22
23	Drywall/Labor			1998	21,125	1,408	15	1,408		6,569	23
24	Carpet			1998	7,927	1,132	7	1,132		4,717	24
25	Awning			1998	3,694	528	7	528		2,244	25
26	Sign			1998	2,000	133	15	133		555	26
27	Wallpaper			1998	2,435	349	7	349		1,569	27
28	Plastic Coat - Roof, Wings			1998	12,500	417	7	417		1,886	28
29	Lavatory Faucets (12)			1998	4,470	298	30	298		1,391	29
30	Overhead Lights (9)			1998	921	61	15	61		285	30
31	Exit Sign			1998	449	30	15	30		140	31
32	Chandeliers - Hall			1998	1,530	102	15	102		493	32
33	Plumbing			1998	9,003	600	15	600		2,700	33
34	Gazebo			1998	3,495	350	10	350		1,720	34
35	Parking Lot Repavement			1998	12,677	1,268	10	1,268		6,234	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Landscaping	1998	8,837	589	15	589		2,749	38
39	Ditch Work	1998	700	47	15	47		230	39
40	Exterior Sign	1998	3,200	213	15	213		835	40
41	Carpet, Window Treatments	1998	30,904	3,090	10	3,090		12,103	41
42	Fuel Tank	1999	8,935	596	15	596		1,987	42
43	Wall Paper	1999	4,135	276	15	276		943	43
44	Paking Lot Resurfacing	1999	3,336	667	15	667		2,223	44
45	Landscaping	1999	976	65	15	65		222	45
46									46
47	Land improvements	2000	646	43	15	43		97	47
48	Kitchen tile	2000	4,230	423	10	423		1,022	48
49	Britlingham air & water	2000	1,992	285	7	285		594	49
50	Handrails	2000	3,819	546	7	546		1,019	50
51									51
52	Tile - Wing 7	2000	3,753	536	7	536		896	52
53	Fire doors	2000	4,861	486	10	486		851	53
54	Landscaping	2001	380	25	15	25		40	54
55	North side heaters	2001	6,090	870	7	870		1,377	55
56	Water heater	2001	15,195	2,170	7	2,170		2,170	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,686,612	$ 74,034		$ 74,034	$	$ 1,152,011	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation (# 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 477,617	$ 45,508	$ 45,508	$	5-10	$ 313,744	71
72	Current Year Purchases	29,116	3,999	3,999		5-10	3,999	72
73	Fully Depreciated Assets	218,245					218,245	73
74								74
75	TOTALS	$ 724,978	$ 49,507	$ 49,507	$		$ 535,988	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility use	1986 Mazda truck	1992	$ 4,474	$	$	$	5	$ 4,474	76
77	Facility use	1996 Chevrolet van	1995	23,548				5	23,548	77
78	Facility use	1998 Ford pickup	2002	9,799	653	653		5	653	78
79										79
80	TOTALS			$ 37,821	$ 653	$ 653	$		$ 28,675	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,628,627	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 124,194	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 124,194	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,716,674	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87			N/A		87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93		N/A	93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Cente # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 12,085 Description: See Supplementary Information for attached schudule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(2), (3)	hrs	$	1,071	$ 51,422	$ 40	1,071	$ 51,462	1
2	Licensed Speech and Language Development Therapist	10A(2), (3)	hrs		206	9,904	40	206	9,944	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), (3)	hrs		1,215	72,885	3,107	1,215	75,992	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				27,086		27,086	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Labs	39(3)				263			263	13
14	TOTAL			$	2,492	$ 134,474	$ 30,273	2,492	$ 164,747	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 08/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,195	$ 4,195	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 355,417)	430,737	430,737	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,964	1,964	6
7	Other Prepaid Expenses	41,676	41,676	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Advances	2,695	2,695	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 481,267	$ 481,267	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	179,216	179,216	13
14	Buildings, at Historical Cost	1,686,612	1,686,612	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	762,799	762,799	16
17	Accumulated Depreciation (book methods)	(1,716,674)	(1,716,674)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 911,953	$ 911,953	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,393,220	$ 1,393,220	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 134,032	$ 134,032	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	28,391	28,391	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,965	21,965	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Advance Billing-Deferred**	65,700	65,700	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 250,088	$ 250,088	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	182,359	182,359	39
40	Mortgage Payable	1,538,793	1,538,793	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,721,152	$ 1,721,152	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,971,240	$ 1,971,240	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (578,020)	$ (578,020)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,393,220	$ 1,393,220	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (252,594)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (252,594)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(325,427)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (325,426)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (578,020)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitatio # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,392,602	1
2	Discounts and Allowances for all Levels	136,495	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,529,097	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	2,726	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,726	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	8,177	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,177	23
	D. Non-Operating Revenue		
24	Contributions	963	24
25	Interest and Other Investment Income***	166	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,129	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See attached	13,398	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,398	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,554,527	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	793,606	31
32	Health Care	1,271,590	32
33	General Administration	482,911	33
	B. Capital Expense		
34	Ownership	158,875	34
	C. Ancillary Expense		
35	Special Cost Centers	172,972	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,879,954	40
41	**Income before Income Taxes (line 30 minus line 40)****	(325,427)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (325,427)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,290	2,387	$ 31,837	$ 13.34	1
2	Assistant Director of Nursing	1,747	1,779	25,869	14.54	2
3	Registered Nurses	12,071	12,369	252,846	20.44	3
4	Licensed Practical Nurses	11,365	11,536	168,163	14.58	4
5	Nurse Aides & Orderlies	34,471	34,833	429,057	12.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,011	2,073	17,587	8.48	9
10	Activity Assistants	3,247	3,400	24,392	7.17	10
11	Social Service Workers	2,240	2,240	20,959	9.36	11
12	Dietician					12
13	Food Service Supervisor	2,385	2,465	27,096	10.99	13
14	Head Cook	4,539	4,931	42,073	8.53	14
15	Cook Helpers/Assistants	11,604	11,721	133,399	11.38	15
16	Dishwashers					16
17	Maintenance Workers	4,930	5,164	43,625	8.45	17
18	Housekeepers	8,420	8,910	108,503	12.18	18
19	Laundry	2,542	2,614	18,298	7.00	19
20	Administrator	2,320	2,320	53,713	23.15	20
21	Assistant Administrator	2,363	2,363	48,349	20.46	21
22	Other Administrative					22
23	Office Manager	2,416	2,416	22,126	9.16	23
24	Clerical	2,487	2,814	18,868	6.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca Care Plans	2,051	2,187	27,625	12.63	32
33	Other(specify) Purchasing agent	120	120	2,327	19.39	33
34	TOTAL (lines 1 - 33)	115,619	118,642	$ 1,516,712 *	$ 12.78	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	118	$ 6,522	1(3)	35
36	Medical Director	Monthly	9,200	9(3)	36
37	Medical Records Consultant	Monthly	1,360	10(3)	37
38	Nurse Consultant	20	770	10(3)	38
39	Pharmacist Consultant	Monthly	2,760	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	2,939	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	138	$ 23,551		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	219	6,526	10(3)	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	219	$ 6,526		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott Cole	Administrator	0	$ 53,713
Gay Edmonds	Asst. Admin.	0	48,349
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,062

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser LLP	Accounting	$ 7,201
American Expr. Tax & Bus. Svcs.	Accounting	1,083
Wilcoxm McGuire & Wyre	Accounting	12,377
Farrar Law Office	Legal	1,372
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 22,033

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,408
Unemployment Compensation Insurance	11,311
FICA Taxes	116,028
Employee Health Insurance	11,504
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	750
Uniforms	1,269
TOTAL (agree to Schedule V, line 22, col.8)	$ 188,270

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
	N/A	
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	4,265
Health Care Worker Background Check	
(Indicate # of checks performed 69)	866
Various licenses & fees	4,645
Various subscriptions	918
Life Services Network of Illinois	1,500
Various dues	544
Long-term Care Solutions	1,200
Less: Fines & Penalties	(3,250)
Less: Public Relations Expense	(460)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,428

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 265
In-State Travel	6,780
Seminar Expense	2,997
Less: out of state travel	(265)
Less: out of period expenses	(1,173)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,604

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Cent # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4			N/A										
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/01 Ending: 08/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network of Illinois 1,500**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **17,298** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **87,600**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **9,764**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wilcox, McGuire & Wyre, CPAs** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Oakview Heights Continuous Care & Rehabilitation Center
Facility ID #: 0026328
8/31/2002 **SUPPLEMENTARY INFORMATION**

Page 3: Other Admin Staff Transportation

Gas and Oil	2,664

Page 5: Adjustment Detail - Line 29 - Other

		xref
Resident expense	(15,265)	43
Offset vending income	(6,792)	1
Disallow nonallowable dues	(460)	20
Disallow out of state & out of period travel	(1,438)	24
	(23,955)	

Page 6: Schedule VII - Related Parties

Board of Directors

Terry Yancy	President
Gary Underwood	Vice Pres
Ronnie Stevens	Treasurer
Roy Biggerstaff	Secretary
Kenneth Curtis	Director
Sharon Russon	Director
James Cowsert	Director
Cecil Winberry	Director
Bob Taylor	Director
Harold Hughes	Director
David Whitten	Director
Bill Willis	Director
Harry Reed	Director
Dan Sitze	Director
Will Schwarzlose	Director

Page 14: Schedule XII (B) - Rental amount for movable equipment

Laundry equipment	630
Dishwasher	1,390
Copier	8,322
Pagers	1,200
Nursing equipment	332
Therapy equipment	211
	12,085

Page 19: Other Income - Line 28

Meal & Vending income	16,566
Sale of Property	(3,168)
	13,398

RECONCILIATION REPORT **Oakview Heights Contin** **03:48 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-71,825	equal to	-71,825	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	22,430	equal to	22,430	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	124,194	equal to	124,194	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	12,085	equal to	12,085	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	137,398	equal to	137,398	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	30,273	equal to	30,273	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	793,606	equal to	793,606	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,271,590	equal to	1,271,590	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	482,911	equal to	482,911	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	158,875	equal to	158,875	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	172,972	equal to	172,972	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	0	equal to	0	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	907,772	equal to	935,397	-27,625	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	41,979	equal to	41,979	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	20,959	equal to	20,959	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	202,568	equal to	202,568	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	43,625	equal to	43,625	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	108,503	equal to	108,503	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	18,298	equal to	18,298	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	102,062	equal to	102,062	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	40,994	equal to	43,321	-2,327	FAILED	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,516,712	equal to	1,516,712	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	6,522	< or = to	6,522	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	9,200	< or = to	9,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	11,416	< or = to	18,079	-6,663	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	0	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,939	< or = to	3,939	-1,000	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	102,062	equal to	102,062	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	22,033	equal to	22,033	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	188,270	equal to	188,270	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	10,428	equal to	10,428	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	8,604	equal to	8,604	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	87,600	equal to		0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,653	equal to	1,653	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,721,152	equal to	1,721,152	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	179,216	equal to	179,216	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,686,612	equal to	1,686,612	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	762,799	equal to	762,799	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,716,674	equal to	1,716,674	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-578,020	equal to	-578,020	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-325,427	equal to	-325,427	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,393,220	equal to	1,393,220	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

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Line 16 for mortgage insurance.